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CLINICAL CASE

Synchronous acute cholecystolithiasis and perforated acute appendicitis. Case report[☆]



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KEYWORDS

Cholecystitis;
Lithiasis;
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Acute;
Synchronous

Abstract

Background: Acute appendicitis and acute cholecystitis are among the most common diagnoses that general surgeons operate on. However, it is rarely described in its synchronous form.

Clinical case: A 43 year-old woman attending the clinic for right upper quadrant pain of 11 days duration. The patient refers to intermittent radiating pain in the right side, with positive Murphy, tachycardia, and fever. The laboratory results showed white cells $16,200/\text{mm}^3$, glucose 345 mg/dl, abnormal liver function tests. Acute cholecystitis was reported with ultrasound. A Masson-type incision was made, noting an enlarged pyogenic gallbladder with thickened walls, sub-hepatic abscess of approximately 300 ml, greenish-yellow color, and fetid. An anterograde subtotal cholecystectomy is performed due to difficulty in identifying elements of Calot triangle due to the inflammatory process, opening it and extracting stones. The right iliac fossa is reviewed, finding a plastron and a sub-serous retrocaecal appendix perforated in its middle third with free fecalith and an abscess in the pelvic cavity. An anterograde appendectomy was performed and the patient progressed satisfactorily, later being discharged due to improvement.

Discussion: In this patient, with a history of recurrent episodes of gallbladder pain and disseminated acute abdominal pain without peritoneal irritation, clinical suspicion was exacerbated cholecystitis with probable empyema of the gallbladder. Open surgery approach for this patient allowed access to both the appendix and gallbladder in order to perform a complete exploration of the abdominal cavity.

Conclusion: The synchronous presentation of cholecystolithiasis and complicated appendicitis has not been reported in the literature.

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PALABRAS CLAVE

Colecistitis;
Litiasis;
Apendicitis;
Aguda;
Sincronía

Colecistitis litiásica crónica agudizada y apendicitis aguda perforada sincrónicas. Reporte de caso

Resumen

Antecedentes: La apendicitis aguda y colecistitis aguda son los diagnósticos más comunes que los cirujanos generales operan. Sin embargo, rara vez se describe su presentación de forma sincrónica.

Caso clínico: Mujer de 43 años que acudió a la consulta por dolor en el hipocondrio derecho de 11 días de evolución, con dolor intermitente irradiado en el hemicinturón derecho, Murphy positivo, taquicardia y fiebre. Leucocitos 16,200/mm³, glucosa 345 mg/dl, pruebas de funcionamiento hepático alteradas, el ultrasonido reportó colelitiasis agudizada. Se realizó incisión tipo Masson obteniendo vesícula a tensión (piocolecisto) con paredes engrosadas, absceso subhepático de aproximadamente 300 ml, color verdoso-amarillento, fétido. Se realizó colecistectomía anterógrada subtotal por dificultad para identificar elementos del triángulo de Calot debido al proceso inflamatorio, con apertura de la misma y extracción de litos; se revisó la fosa iliaca derecha encontrando plastrón y apéndice retrocecal subseroso perforado en su tercio medio, con fecalito libre y absceso en hueco pélvico por lo que se realiza una apendicectomía parcial anterógrada. La paciente evolucionó satisfactoriamente siendo dada de alta por mejoría.

Discusión: En esta paciente, con el antecedente de cuadros recurrentes de dolor vesicular y con dolor abdominal agudo diseminado, y sin datos de irritación peritoneal, la sospecha clínica fue colecistitis litiásica agudizada con probable piocolecisto. El abordaje abierto para esta paciente permitió el acceso tanto al apéndice como a la vesícula biliar, permitiendo realizar la exploración de la cavidad abdominal.

Conclusión: La presentación sincrónica de colelitiasis agudizada y apendicitis aguda complicada (perforada) no ha sido informada en la literatura médica.

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Background

Synchronous appendicitis and cholecystitis have rarely been reported, most have been described as cholecystolithiasis and appendicitis in the early stages, and in pregnant patients (within the same gestation period), in other words, not absolutely synchronous. The few reported cases are from Eastern Europe, and one case from Argentina.¹⁻⁴

Clinical case

A 43-year old woman attending General Surgery with pain in the right hypochondrium. The patient had intermittent, irradiated, right-sided girdling pain, positive Murphy's sign, vital signs: blood pressure 120/70 mmHg, heart rate 100/min, respiratory frequency 20/min, temperature 38.5 °C. Laboratory report: hemoglobin 10.7 g/dl, leukocytes 16,200/mm³, segmented neutrophils 82%, prothrombin time 14.9 s, partial thromboplastin time 40.9 s, glucose 345 mg/dl; liver function tests: direct bilirubin 1.82 mg/dl, indirect bilirubin 0.50 mg/dl, total bilirubin 2.32 mg/dl, albumin 2.77 g/dl, albumin to globulin ratio 0.62 IU/l, gamma-glutamyl transferase 404 U/l, rest normal. Ultrasound reported acute cholecystolithiasis, and therefore a diagnosis of cholecystolithiasis was integrated.

A Masson incision was made with the following findings: gallbladder under tension (empyema) with thickened walls, on exploration adhesions were released, and a subhepatic abscess was opened of approximately 300 ml, greenish yellow in color and fetid (anaerobes), a subtotal anterograde cholecystectomy was performed at the level of the gallbladder neck opening same and extracting stones, the largest was 2 cm and round and 2 more which were faceted. When evacuation of the abscess, and the simple cholecystectomy were completed the right iliac fossa was reviewed, finding a plastron and sub-serous retrocaecal appendix perforated in its middle third with free fecalith of 2 cm × 6 cm (Fig. 1) with an abscess in the pelvic cavity and right groove, an anterograde appendectomy was performed. The patient made satisfactory progress and was discharged on the 5th day of her hospital stay as her condition had improved and she was tolerating an oral diet, with return of normal elimination.

Discussion

An important principle of medical diagnosis is the acute onset of symptoms, and the constellation of signs which should provide a better diagnosis. However, in this patient with a history of recurring gallbladder pain, with acute disseminated abdominal pain and no signs of peritoneal irritation, the clinical suspicion was acute cholecystitis with

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